

However, if a service is medically necessary, it must be provided by the MCO/BHO without regard to tentative service benefits limits. Whenever an MCO or BHO states that there is a tentative limit on EPSDT services, enrollees and providers must be told that if medical necessity can be shown, such limit(s) can be waived. The criteria set forth in this TSOP must be forwarded to your provider network to ensure that each child's needs are met.

Screening Requirements

The Bureau of TennCare has adopted the periodicity schedule recommended by the American Academy of Pediatrics for Preventive Pediatric Health Care¹. Immunizations should be provided in accordance with the Recommended Childhood Immunization Schedule, as approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Physicians (AAFP). As these schedules are reviewed, updated, and revised, the Bureau of TennCare will inform MCOs/BHOs of any changes that may be different from those published. MCOs/BHOs will then need to inform their provider network of any changes.

MCOs/BHOs must provide to eligible EPSDT enrollees who request it, screening services (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. As a minimum, these screenings must include, but not limited to:

- P Comprehensive health and developmental history (including assessment of both physical and mental health development and dietary practices).
- P Comprehensive unclothed physical examination (the child's physical growth shall be compared against that considered normal for the child's age).
- P Laboratory tests (including blood level assessment appropriate to age and risk).
- P Vision testing, to be age appropriate, including diagnosis and treatment for defects in vision, including eyeglasses.
- P Hearing testing, to be age appropriate, including diagnosis and treatment for defects in hearing, including hearing aids.
- P Appropriate laboratory testing (see below).
- P Appropriate immunizations (see below).
- P Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. This referral for services is for preventive dental care and screening in accordance with the dental periodicity schedule. At a minimum, to include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services shall be performed by or under the supervision of dentists. Dental services may not be limited to emergencies.

P Health education including anticipatory guidance, i.e., counseling to both parent and child to “assist in understanding what to expect in terms of the child’s development and to provide information about the benefits of healthy life style and practices as well as accident and disease prevention.” (HCFA State Medicaid Manual Section 5123.2[E])

The medical screen shall be consistent with HCFA minimum standards. HCFA currently requires at least the following, as medically appropriate: anemia test, sickle cell testing, and tuberculin test. In addition to these, the child’s age, sex and health history, clinical systems and exposure to disease can make additional tests necessary, such as urine screening, pinworm slides, urine cultures, serological tests, drug dependence screening, stool specimens for parasite and ova, blood and HIV screening.

The medical screen is also to include appropriate childhood immunizations as recommended by the Center for Disease Control’s (CDC) Advisory Committee on Immunization Practices. Currently, EPSDT must cover diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, varicella zoster (for chicken pox), and hemophilus b conjugate (Hib) vaccines. Immunizations that may be appropriate based on age and health history but which are medically contraindicated at the time of the screening may be rescheduled at an appropriate time.

A child below the age of six (6) shall also be tested for lead blood poisoning in accordance with current CDC and/or American Academy of Pediatrics recommendations. Children who test high (consistent with CDC measures) and children who are deemed to be “high risk” as a result of the verbal risk assessment must receive follow up consistent with current CDC, and/or American Academy of Pediatrics recommendations.

Screening Service Content

A. Comprehensive Health and Developmental History

This information should be obtained from the parent or other responsible adult who is familiar with the child’s history and includes an assessment of both physical and mental health developments. Coupled with the physical exam, this includes:

1. Developmental Assessment

This includes a range of activities to determine whether an individual’s developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for developmental assessment is a part of every routine initial and periodic examination.

Developmental assessment is also carried out by professionals to whom children are referred for structured tests and instruments after potential problems have been identified by the screening process. You may build the two aspects into the program so that fewer referrals are made for additional developmental assessment.

a. Approach: There is no universal list of dimensions of development for the different age ranges of childhood and adolescence. In younger children, assess at least the following elements:

- Gross motor development, focusing on strength, balance, locomotion;
- Fine motor development, focusing on eye-hand coordination;
- Communication skills or language development, focusing on expression, comprehension, and speech articulation;
- Self-help and self-care skills;
- Social-emotional development, focusing on the ability to engage in social interaction with other children, adolescents, parents, and other adults; and
- Cognitive skills, focusing on problem solving or reasoning.

As the child grows through school age, focus screens on visual-motor integration, visual-spatial organization, visual sequential memory, attention skills, auditory processing skills, and auditory sequential memory. Most school systems provide routines and resources for developmental screening.

For adolescents, the orientation should encompass such areas of special concern as the potential presence of learning disabilities, peer relations, psychological/psychiatric problems, and vocational skills.

b. Procedures: No list of specified tests and instruments is prescribed for identifying developmental problems because of the large number of such instruments, development of new approaches, the number of children and the complexity of developmental problems which occur, and to avoid the connotation that only certain tests or instruments satisfy Federal requirements. However, the following principles must be considered:

- Acquire information on the child's usual functioning, as reported by the child, parent, teacher, health professional, or other familiar person.
- In screening for developmental assessment, the examiner incorporates and reviews this information in conjunction with other information gathered during the physical examination and makes the objective professional judgment whether the child is in the expected range. Review developmental progress, not in isolation, but as a component of overall health and well being, given the child's age and culture.
- Developmental assessment should be culturally sensitive and valid. Do not dismiss or excuse improperly potential problems on grounds of culturally appropriate behavior. Do not initiate referrals for factors associated with cultural heritage.
- Screens should not result in a label or premature diagnosis of a child. Providers should report only that a condition was referred or that a type of diagnostic or treatment service is needed. Results of initial screening should not be accepted as conclusions and do not represent a diagnosis.

- Refer to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up when concerns or questions remain after the screening process.

2. Assessment of Nutritional Status

This is accomplished in the basic examination through:

- Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets which are deficient or excessive in one or more nutrients.
- A complete physical examination including an oral dental examination. Pay special attention to such general features as pallor, apathy, and irritability.
- Accurate measurements of height and weight, which are among the most important indices of nutritional status.
- A laboratory test to screen for iron deficiency. HCFA and PHS recommend that the erythrocyte protoporphyrin (EP) test be utilized when possible for children ages 1-5. Where the EP test is not available, use hemoglobin concentration or hematocrit.
- If feasible, screen children over 1 year of age for serum cholesterol determination, especially those with a family history of heart disease and/or hypertension and stroke.

If information suggests dietary inadequacy, obesity or other nutritional problems, further assessment is indicated, including:

- Family, socioeconomic or community factors,
- Determining quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs),
- Further physical and laboratory examinations, and
- Preventive, treatment and follow-up services, including dietary counseling and nutrition education.

B. Comprehensive Unclothed Physical Examination

Which includes the following:

- Physical Growth: Record and compare the child's height and weight with those considered normal for that age. In the first year of life, head circumference measurements are important. Use a graphic recording sheet to chart height and weight over time.

- **Unclothed Physical Inspection:** Check the general appearance of the child to determine overall health status. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

C. Appropriate Immunizations²

Assess whether the child has been immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b conjugate (Hib), Hepatitis B, and varicella zoster (chickenpox); and whatever booster shots are needed. The child's immunization record should be available to the provider.

Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP). These recommendations will be used to determine when Federal Financial Participation (FFP) is not available for single antigen vaccines (unless a combined antigen was medically contraindicated).

D. Appropriate Laboratory Tests

Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups. Examples of some of the tests to be considered as part of the statewide screening requirement are hematocrit or hemoglobin screening, urinalysis, TB skin testing, STD screening, and cholesterol screening. With the exception of lead toxicity screening, physicians providing screening services under EPSDT program use their medical judgment in determining the applicability of the laboratory tests or analyses to be performed. Lead toxicity screening must be performed as indicated below.

(1) Lead Toxicity Screening:

All children are considered at risk and must be screened for lead poisoning. HCFA requires the use of the blood lead test when screening children for lead poisoning. The EP test is no longer acceptable as a screening test for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning.

❖Risk Assessment: All children from 6 to 72 months of age are considered at risk and must be screened. Beginning at 6 months of age and at each visit thereafter, the provider must discuss with the child's parent or guardian, childhood lead poisoning interventions and assess the child's risk for exposure. Questions should be asked that aid the physician in determining exposure to lead poisoning in the child's home environment, day care, preschool or babysitter's home, contact with those adults who may work with lead (ex: construction or welding), location to factories involved with lead, etc.

❖Determining Risk: Risk is determined from the response to the questions that Tennessee requires for verbal risk assessment³. If the answers to all questions are negative, a child is considered low risk for high doses of lead exposure, but must

receive blood lead screening by blood lead test at 12 months of age and 24 months of age.

If the answer to any question is positive, a child is considered high risk for high doses of lead exposure. A blood lead test must be obtained at the time a child is determined to be high risk.

Subsequent verbal risk assessments can change a child's risk category. If as the result of a verbal risk assessment a previously low risk child is recategorized as high risk, that child must be given a blood lead test.

❖Screening Blood Tests: The term "screening blood tests" refers to blood tests for children who have not previously been tested for lead with a blood test or who have been previously tested and found not to have an elevated blood lead level. If a child is determined by the verbal risk assessment to be at:

- (1) Low Risk: A screening blood lead level is required at 12 months of age and a second blood lead test at 24 months of age.
- (2) High Risk: A blood lead test is required when a child is identified as being high risk, beginning at six (6) months of age. If the initial blood lead level test results are less than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$), a screening blood lead test is required at every prescribed interval in TennCare's EPSDT periodicity schedule through 72 months of age,

Unless the child has already received a blood lead test within the last six (6) months of the periodic visit. A blood lead test result equal to or greater than 10 $\mu\text{g}/\text{dL}$ obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

If a child between the ages of 24 months and 72 months has not received a screening blood lead test, then that child must receive it immediately, regardless of being determined at low or high risk.

❖Diagnosis, Treatment, and Follow-up: If a child is found to have a blood lead levels equal to or greater than 10 $\mu\text{g}/\text{dL}$, providers are to use their professional judgment, with reference to CDC guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to determine the source of lead, where indicated.

❖Coordination With Other Agencies: MCOs/BHOs shall work with the Bureau and WIC, Head Start, and other public and private resources to aid in eliminating duplicate testing and ensure comprehensive diagnosis and treatment. Also, public health agencies' childhood lead poisoning prevention programs may be available. These

agencies may have authority and ability to investigate a lead-poisoned child's environment and to require remediation.

(2) Anemia Test:

The most easily administered test for anemia is a microhematocrit determination from venous blood or a fingerstick.

(3) Sickle Cell Test:

Diagnosis for sickle cell trait may be done with sickle cell preparation or a hemoglobin solubility test. If a child has been properly tested for sickle cell disease, the test need not be repeated.

(4) Tuberculin Test:

Give a tuberculin test to every child who has not received one within a year.

(5) Others:

In addition to the tests above, there are several other tests to consider. An individual's age, sex, health history, clinical symptoms and exposure determine their appropriateness to disease. These include a urine screening, pinworm slide, urine culture (for girls), serological test, drug dependency screening, stool specimen for parasites, ova, blood, and HIV screening.

E. Health Education

Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives providers the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

F. Vision and Hearing Screens

Vision and hearing screens are subject to their own periodicity schedules. However, where the periodicity schedules coincide with the schedule for screening services, MCOs/BHOs may include vision and hearing screens as a part of the required minimum screening services.

1. Appropriate Vision Screen⁴: An age-appropriate vision assessment must be administered. Consultation by ophthalmologists and optometrists can help determine the type of procedures to use and the criteria for determining when a child is referred for diagnostic examination.

Ocular alignment and visual acuity once in the 3-6 year old age range. These procedures should be conducted at the first visit during which the patient is cooperative. Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 m, or Random Dot E Sterotest at 40 cm (630 secs of arc).

Visual acuity should be tested once in each of the following age ranges: 10-13 years old and 14-18 years old. Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Picture Tests, Allen Figures, or LH Tests.

Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather waiting until the next scheduled well child visit.

2. Appropriate Hearing Screen⁵: An age-appropriate hearing assessment must be administered. Obtain consultation and suitable procedures for screening and methods of administering them from audiologists, or from the State Health Department or Education Department.

Newborn hearing screening is recommended for all newborns, and are most likely to occur in hospitals with the results reported to the primary care provider. Currently (1999), not all hospitals in the state have the capability of conducting newborn hearing screening. Newborn hearing screenings should be provided for all newborns by the year 2003. Acceptable methods of screening include auditory brainstem response (ABR) and otoacoustic emissions (OAF) with thresholds of 30 dB HL.

An objective hearing screening test should be done once in each of the following age ranges: 3-6 years old, 10-13 years old, and 14-18 years old. Screening should be conducted at the first visit during which the patient is cooperative during the above listed intervals. Acceptable methods of objective hearing screening include conventional audiometry, hand-held audiometry, or conditioned play audiometry (with a screening level of 20 dB HL at 500, 1000, 2000, and 4000Hz).

Positive screening results should lead to referral for diagnostic assessment of hearing. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes the initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather waiting until the next scheduled well child visit.

G. Dental Screening Services⁶:

Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the established periodicity schedules and at other intervals as medically necessary. An eligible child shall be referred to a dentist beginning at the age 3, or earlier if determined to be medically necessary.

Especially in older children, the periodicity schedule for dental examinations is not governed by the schedule for medical examinations. Dental examinations of older children should occur with greater frequency than is the case with physical examinations. The referral must be for an encounter with a dentist, or a professional dental hygienist under the supervision of a dentist, for diagnosis and treatment. However, where any screening, even as early as the neonatal examination, indicates that dental services are needed at an earlier age, the needed dental services are to be provided.

The requirement of a direct referral to a dentist can be met in settings other than a dentist's office. The necessary element is that a dentist or other dental professional under the supervision of a dentist examines the child. In an area where dentists are scarce or not easy to reach, dental examinations in a clinic or group setting may make the service more appealing to enrollees while meeting the dental periodicity schedule. If continuing care providers have dentists on their staff, the direct referral to a dentist requirement is met. Dental paraprofessionals under direct supervision of a dentist may perform routine services when in compliance with State of Tennessee practice acts.

¹See Attachment A

²See Attachment B

³See Attachment C

⁴See Attachment D

⁵See Attachment E

⁶See Attachment F

TennCare Authority:

42 U.S.C. §§ 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)
42 C.F.R. § 440.230
42 C.F.R. § 441, Subpart B
HCFA's State Medicaid Manual
TennCare Rules and Regulation 1200-13-12-.04(1)(w)
TennCare/MCO Contract Section 2-3.a.1.; Section 4-8.
TennCare/BHO Contract Section 2.6.1.; Section 5.3.3.1.

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ATTACHMENT A

PERIODICITY SCHEDULE FOR EPSDT CHECK-UPS/SCREENS

ATTACHMENT A

PERIODICITY SCHEDULE FOR EPSDT CHECK-UPS/SCREENS

At Birth	6 years old
2-4 days of age	8 years old
1 month old	10 years old
2 months old	11 years old
4 months old	12 years old
6 months old	13 years old
9 months old	14 years old
15 months old	15 years old
18 months old	16 years old
24 months old	17 years old
3 years old	18 years old
4 years old	19 years old
5 years old	20 years old

APPENDIX B

IMMUNIZATION SCHEDULE

Recommended Childhood Immunization Schedule

United States, January – December 1999

Vaccines¹ are listed under routine recommended ages. Bars indicate range of acceptable ages for immunization. Any dose not given at the recommended age should be given as a “catch-up” immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Age Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B ²	Hep B										
		Hep			Hep B						
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP		DTaP ⁴		DTaP	Td	
H. influenzae type b ⁴			Hib	Hib	Hib	Hib					
Polio ⁵			IPV	IPV	Polio ⁵					Polio	
Rotavirus ⁶			Rv ⁶	Rv ⁶	Rv ⁶						
Measles, Mumps, Rubella ⁷						MMR		MMR ⁷	M		
Varicella ⁸						Var					

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Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Phys. (AAFP)

¹ This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combinations are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

² **Infants born to HBsAg-negative mothers** should receive the 2nd dose of hepatitis B vaccine at least 1 month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 ml hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1 – 2 months of age and the 3rd dose at 6 months of age.

Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age). All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of HBV infection.

³ DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the immunization series, including completion of the series in children who have received 1 or more doses of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose (DTP or DTaP) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose and if the child is unlikely to return at ages 15 – 18 months. Td (tetanus and diphtheria toxoids) is recommended at 11 – 12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

⁴ Three (3) *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB and COMPAX [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4, or 6 months of age, unless FDA-approved for these ages.

⁵ Two (2) poliovirus vaccines are currently licensed in the United States: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The ACIP, AAP, and AAFP now recommend that the first two (2) doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of poliovirus vaccine should be IPV administered at ages 2 and 4 months, followed by 2 doses of OPV at 12 – 18 months and 4 – 6 years. Use of IPV for all doses also is acceptable and is recommended for immunocompromised persons and their household contacts. OPV is no longer recommended for the first two (2) doses of the schedule and is acceptable only for special circumstances such as: children of parents who do not accept the recommended number of injections, late initiation of immunization which would require an unacceptable number of injections, and imminent travel to polio-endemic areas. OPV remains the vaccine of choice for mass immunization campaigns to control outbreaks due to wild poliovirus.

⁶ Rotavirus (Rv) is shaded to indicate: 1) health care providers may require time and resources to incorporate this new vaccine into practice; and 2) the AAFP feels the decision to use rotavirus vaccine should be made by the parent or guardian in consultation with their physician or other health care provider. The first dose of Rv vaccine should not be administered before 6 weeks of age, and the minimum interval between doses is 3 weeks. The Rv vaccine should not be initiated at 7 months of age or older, and all doses should be completed by the first birthday.

⁷ The 2nd dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at 4 – 6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should be complete the schedule by the 11 – 12-year-old visit.

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⁸ Varicella vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e., those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or over should receive 2 doses, given at least 4 weeks apart,

ATTACHMENT C

LEAD RISK ASSESSMENT

ATTACHMENT C

Lead Risk Assessment Questions

1. Does your child live in or regularly visit a home with peeling or chipping paint built before 1960? (This could include a day care center, home of a baby sitter, or relative.)
2. Does your child live in a house built before 1978 with recent, or ongoing, or planned renovations or remodeling?
3. Does your child frequently come in contact with an adult who works with lead? (Examples: construction, welding, pottery, or other trades or hobbies that utilize lead.)
4. Does your home contain any plastic or vinyl mini blinds?
5. Have you been told your child has low iron?
6. Have any of your children or their playmates had lead poisoning?
7. Have you seen your child eating paint chips, crayons, soil or dirt?
8. Does your child live near a lead smelter, battery recycling plant or other industry that is likely to release lead? (Give examples in the child's community.)
9. Do you give your child any home or folk remedies, which may contain lead? (Give examples such as Moonshine, Azarcon, Greta, and Paylooah.)
10. Does your child live within 80 feet of a heavily traveled road or on a heavily traveled street?
11. Does your home's plumbing have lead pipes or copper with lead solder joints?
12. Does your family use pottery ware or leaded crystal for cooking, eating, or drinking?

Determining Risk Factors

Risk is determined from the response to the questions on the verbal risk assessment.

- If all the answers are negative a child is considered **low risk**. Low risk children continue to be assessed for risk from 6 months to 60 months of age. For low risk children residing in the designated high risk counties, a blood lead level is required at 12 months and a second blood lead level at 24 months during routine well-child exam.

The following counties have identified as being high-risk areas for childhood lead poisoning:

Bedford	Giles	Putnam
Bradley	Hamilton	Rutherford
Cumberland	Knox	Shelby
Davidson	Madison	Sullivan
Fayette	Maury	Sumner
Gibson	Montgomery	Tipton

*As risk factors change over time, so may the targeted counties. Up dates will be issued as appropriate.

- If the answer to any question is positive, a child is considered high risk. A blood level (BLL) should be obtained on any child identified to be high-risk during the screening exams a six (6), twelve (12), twenty-four (24), thirty-six (36), and sixty (60) months of age. Once identified as high-risk, a child's BLL should be followed at least to the age of 24 months. If the BLL is less than 10 $\mu\text{g/dL}$ at 24 months, then no further screenings are required unless that child moves to another house prior to 72 months of age, or other previous negative risk factors become positive.
- All elevated blood levels must be confirmed by venous blood sampling. The time between the initial capillary screening and venous confirmation must be based on the criteria below.

If the result of the screening test
($\mu\text{g/dL}$) is: _____

10 - 19
20 - 44
45 - 59
60 - 69
 \geq 70

Perform diagnostic test on
venous blood within: _____

3 months
1 month - 1 week*
48 hours
24 hours
immediately as an
emergency lab test

*The higher the screening BLL, the more urgent the need for a confirmation test.

ATTACHMENT D

VISION SCREENING

ATTACHMENT D
VISION SCREENING

Recommendations for Subjective Vision Screening	Recommendations for Objective Vision Screening
Newborn	Eye exam: red reflex, corneal inspection
2 - 4 days	Eye exam: red reflex, corneal inspection
By one month Parental perception of vision	Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
2 months Parental perception of vision	Eye exam: red reflex, corneal inspection Fixes on face, follows with eyes
3 months Parental perception of vision	Eye exam - fixes and follows each eye
4 months Parental perception of vision	Eye exam - fixes and follows each eye
6 months Parental perception of vision	Eye exam - fixes and follows each eye
9 months Parental perception of vision	Eye exam - fixes and follows each eye
12 months Parental perception of vision	Eye exam - fixes and follows each eye
15 months Parental perception of vision Can see small objects	Eye exam Can see small objects
18 months Parental perception of vision Can see small objects	Eye exam Can see small objects
24 months Parental perception of vision Can see small objects	Eye exam Can see small objects
3 years Parental perception of vision Can see small objects	Eye exam - Ocular alignment, visual acuity (optional) Can see small objects

4 years	Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3 years)
5 years	Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3 or 4 years)
6 years	Parental perception of vision	Eye exam - Ocular alignment, visual acuity (if not done at 3, 4, or 5 years)
7 years	Parental and patient perception of vision	Eye exam
8 years	Parental and patient perception of vision	Eye exam
9 years	Parental and patient perception of vision	Eye exam
10 years	Parental and patient perception of vision	Eye exam - Visual Acuity
11 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10 years)
12 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10 or 11 years)
13 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 10, 11, or 12 years)
14 years	Parental and patient perception of vision	Eye exam - Visual Acuity
15 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14 years)
16 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14 or 15 years)
17 years	Parental and patient perception of vision	Eye exam - Visual Acuity(if not done at 14, 15, or 16 years)
18 years	Parental and patient perception of vision	Eye exam - Visual Acuity (if not done at 14, 15, 16, or 17 years)
19 years	Parental and patient perception of vision	Eye exam

20 years	Parental and patient perception of vision	Eye exam
21 years	Parental and patient perception of vision	Eye exam

ATTACHMENT E

HEARING SCREENING

ATTACHMENT E
HEARING SCREENING

Recommendations for Subjective Hearing Screening	Recommendations for Objective Hearing Screening
Newborn Parental perception of hearing Family history Wakes to loud noises Head turning to voice/noise	ABR or OAE, if performed in hospital Observational screening with noisemaker (optional)
2 - 4 days Parental perception of hearing Family history Response to voice and noise - parental report	ABR or OAE, if performed in hospital Observational screening with noisemaker (optional)
By 1 month Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
2 months Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
3 months Parental perception of hearing Family history (unless previously recorded) Response to voice and noise - parental report	Ear exam Observational screening with noisemaker (optional)
4 months Parental perception of hearing Recognizes parent's voice - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
5 months Parental perception of hearing Recognizes parent's voice - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
6 months Parental perception of hearing Turns to sound - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)

9 months	Parental perception of hearing Response to voice and noise - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
12 months	Parental perception of hearing Response to voice and noise - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
15 months	Parental perception of hearing Response to voice and noise - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
18 months	Parental perception of hearing Response to voice and noise - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
24 months	Parental perception of hearing Response to voice and noise - parental report Family history (unless previously recorded)	Ear exam Observational screening with noisemaker (optional)
3 years	Parental perception of hearing	Ear exam Hearing Screen (optional) Observational screening with noisemaker (optional)
4 years	Parental perception of hearing	Ear exam Hearing Screen (if not done at 3 years)
5 years	Parental perception of hearing	Ear exam Hearing Screen (if not done at 3 or 4 years)
6 years	Parental perception of hearing	Ear exam Hearing Screen (if not done at 3, 4 or 5 years)
7 years	Parental and patient perception of hearing	Ear exam Hearing Screen
8 years	Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7 years)

9 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7 or 8 years)
10 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, or 9 years)
11 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, or 10 years)
12 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, 10, or 11 years)
13 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 7, 8, 9, 10, 11, or 12 years)
14 years Parental and patient perception of hearing	Ear exam Hearing Screen
15 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14 years)
16 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14 or 15 years)
17 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14, 15, or 16 years)
18 years Parental and patient perception of hearing	Ear exam Hearing Screen (if not done at 14, 15, 16, or 17 years)
19 years Parental and patient perception of hearing	Ear exam
20 years Parental and patient perception of hearing	Ear exam

21 years	Parental and patient perception of hearing	Ear exam
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ATTACHMENT F

DENTAL SCREENING

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC DENTAL CARE*

Because each child is unique these Recommendations are designed for the care of children who have no important health problems and are developing normally. These Recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations. The Academy emphasizes the important of very early professional intervention and the continuity of care based on the individualized needs of the child.

Recommended Pediodontic Care

Required by contract
beginning at 3 years of age

Age ¹	Infancy 6-12 Mons.	Late Infancy 12-24 Mons.	Preschool 2-6 Years	School-Aged 6-12 Years	Adolescence 12-21 Years
Oral Hygiene ² Counseling	Parents/Guardians/ Caregivers	Parents/Guardians/ Caregivers	Child/Parent/ Caregivers	Child/Parent/ Caregivers	Patient
Injury Prevention ³ Counseling	*	*	*	*	*
Dietary Counseling ⁴	*	*	*	*	*
Counseling for ⁵ Non-nutritive Habits	*	*	*	*	*
Fluoride ⁶ Supplementation	*	*	*	*	*
Assess Oral Growth ⁷ & Development	*	*	*	*	*
Clinical Oral Exam every 6 mo.	*	*	*	*	*
Prophylaxis and ⁸ Topical Fluoride Treatment every 6 mo.	*	*	*	*	*
Radiographic ⁹ Assessment	*	*	*	*	*
Pit & Fissure Sealant			If indicated on primary molars	1st permanent molars as soon as possible after eruption	2 nd permanent molars as soon as possible after eruption
Treatment of Dental Disease/Injury	*	*	*	*	*
Assessment and Treatment of Developing Malocclusion			*	*	*
Substance Abuse Counseling				*	*
Assessment and Removal of 3 rd molar					*
Referral for Regular and Periodic Dental Care					*
Anticipatory Guidance ¹⁰	*	*	*	*	*
Notes:					

1. First exam at the eruption of the first tooth and no later than 12-18 months.
2. Initially, responsibility of parent; as child develops jointly with parents; then when indicated only child.
3. Initially play objects, pacifiers, car seats; then when learning to walk; and finally sports and routine playing.
4. At every appointment discuss the role of refined carbohydrates; frequency of snacking.
5. At first discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before the eruption of the first permanent front teeth.
6. As per AAP/ADA Guidelines and the water source.
7. By clinical examination.
8. Especially for children at high risk for caries and periodontal disease.
9. As per AAPD Radiographic Guidelines.
10. Appropriate discussion and counseling, should be an integral part of each visit for caries.

**American Academy of Pediatric Dentistry, May, 1992.*